State of Rhode Island and Providence Plantations

WORKERS' COMPENSATION COURT

J. JOSEPH GARRAHY JUDICIAL COMPLEX
ONE DORRANCE PLAZA
PROVIDENCE, R.I. 02903-3973

1. NAME OF INJURED EMPLOYEE — Petitioner / Social Security Number - -	5. NAME OF EMPLOYER — Respondent
2. HOME ADDRESS (Street, No., City or Town, State and Zip Code) / Date Of Birth	6. BUSINESS ADDRESS (Street, No., City or Town, State and Zip Code) / 7a. NAME OF AGENT FOR SERVICE OF PROCESS
3. DESCRIPTION OF EMPLOYEE'S JOB	7b. ADDRESS OF AGENT FOR SERVICE OR PROCESS
4. NATURE OF EMPLOYER'S BUSINESS	8. NAME OF EMPLOYER'S INSURANCE CARRIER ON DATE OF ALLEGED INJURY

9. DATE OF ALLEGED INJURY (Month, Day, Year) TIME

10. DID INJURY OCCUR ON EMPLOYER'S PREMISES ☐ Yes ☐ No

11. IF NOT ON EMPLOYER'S PREMISES, STATE WHERE INJURY OCCURED

12. NAME(S) AND ADDRESS(ES) OF WITNESS(ES) TO INJURY

13. HOW DID INJURY OCCUR?

14. NATURE OF INJURY AND PARTS OF BODY AFFECTED BY INJURY

15. NAME(S) OF PHYSICIAN(S) AND HOSPITAL(S) WHO HAVE RENDERED SERVICES

16. WEEKLY WAGES AT TIME OF INJURY

17. FIRST DAY OF LOST TIME

18. (a) DID YOU RECEIVE WAGES FROM YOUR EMPLOYER WHILE ABSENT FROM WORK? ☐ Yes ☐ No (b) IF SO, TO WHAT DATE? DATE:

19. (a) DID YOU RETURN TO WORK FOLLOWING THE INJURY? ☐ Yes ☐ No (b) WHEN DATE:

20. (a) FOR WHOM DID YOU RETURN TO WORK (Give Name and Address)? (b) AT WHAT WEEKLY WAGE?

21. NAME AND TITLE OF PERSON IN EMPLOY OF YOUR EMPLOYER, WHOM YOU NOTIFIED, OR WHO HAD KNOWLEDGE OF YOUR INJURY

22. (a) DID YOU RECEIVE WORKERS' COMPENSATION BENEFITS FROM YOUR EMPLOYER FOR THE ABOVE INJURY? ☐ Yes ☐ No (b) TO WHAT DATE? DATE:

23. WAS A PRELIMINARY AGREEMENT CONCERNING COMPENSATION BENEFITS ENTERED INTO WITH YOUR EMPLOYER? ☐ Yes ☐ No

24. WAS IT A NON-PREJUDICIAL AGREEMENT? ☐ Yes ☐ No

25. CHECK BELOW THE BENEFITS YOU ARE SEEKING:

☐ TOTAL DISABILITY COMPENSATION FROM TO

☐ PARTIAL DISABILITY COMPENSATION FROM TO

☐ MEDICAL BENEFITS

☐ DEPENDENCY BENEFITS (SEE SEC. 28-33-17) NAME OF WHOLLY DEPENDENT WIFE; OR PHYSICALLY INCAPACITATED HUSBAND. NAMES AND AGES OF DEPENDENT CHILDREN.

☐ PERMISSION TO HAVE MAJOR SURGERY PERFORMED, NAMELY:

☐ SPECIFIC COMPENSATION CONCERNING THE FOLLOWING BODILY MEMBERS OR FUNCTIONS:

☐ COUNSEL, WITNESS AND SHERIFF'S FEES

I hereby petition that my rights to benefits under the Workers' Compensation Act may be determined, and in support of this petition I make the foregoing statement of facts. I further certify that both my employer and I are subject to the provisions of the Workers' Compensation Act; that my injury was not occasioned by my wilful intention to bring about the injury or death of myself or another; and that said injury did not result from my intoxication on duty or unlawful use of controlled substances.

I have read the above statements and affirm that the same are true.

Name, Address and Registration Number for the Attorney for Employee

Signature of Employee

Date

W.C.C.9 (rev. 1/98)

ORIGINAL